October 1, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-03-1770-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

On ___, ___, a 52-year-old man, was injured at work. He was seen the following day in the office of ___, who reported that the patient "smashed his finger at work." An examination revealed that this patient's left fifth finger had ecchymosis across the end. X-rays showed displaced distal phalangeal fracture, and he was scheduled for a surgical pin of the fracture. The procedure was carried out. He was followed post-op for a couple of months, had a physical therapy program, and was alter released back to work.

In the summer of 2002, ___presented with complaints of numbness in his hands. He was seen on independent review on 6/3/02 by ___ who was unable to correlate the "numbness" to the original distal phalanx fifth finger injury.

In December 2002, the patient had electrodiagnostic studies that gave evidence of marked bilateral carpal tunnel syndrome. He later had CTS surgery on the left. The relationship of this to the original left fifth finger injury has been disputed.

REQUESTED SERVICE

A six-week work hardening program is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer agrees that the requested work hardening is not indicated and is not justified in this case. The on-the-job injury was that of a specific focal crush-type injury to the distal phalanx of the left finger only. There was no "left-hand crush."

The numbness symptoms that came on several months later were documented as severe bilateral carpal tunnel syndrome (the nerve conduction studies are noted.) This would not be related to the specific fifth finger injury of ___.

Any current symptoms of hand numbness, generalized hand pains, anxiety and depression, would not be related to the fifth finger distal phalanx injury/fracture. Thus, the reviewer finds himself in agreement with the utilization review notice of adverse determination appeal dated 8/1/03.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 1st day of October 2003.